

Request for Dispute Resolution ___ Original ___ Response		Has employer accepted this claim? ___ Yes ___ No Has liability for injury been found by the WCAB? ___ Yes ___ No Has more than 90 days of TTD been paid? ___ Yes ___ No		Rehabilitation Use Only	
Social Security Number			WCAB Number		Rehab Unit Number
Employee Name (Last)		(First)	(MI)		Date of Birth
Address (Street)		(City)		(State)	(Zip)
Employer Name			Insurance Company Name; Or, if Self-Insured, Certificate Name		
Address			Adjusting Agency Name (if adjusted)		
City, State, Zip			Claims Mailing Address		
Date of Injury		Claim Number		City, State, Zip Phone No.	
Employee Representative			Employer Representative		
Firm Name			Firm Name		
Address			Address		
City, State, Zip		Phone No.		City, State, Zip Phone No.	
Qualified Rehabilitation Representative					
Firm Name			Representative Name		
Address (Street, City, State, Zip)					Phone No.
The Rehabilitation Unit is requested to resolve the following dispute on an expedited basis because the parties disagree on : (Check the single issue which applies) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> ___ The identification of a vocational goal (for injuries after 1/1/94) ___ The selection of a Independent Vocational Evaluator </div> <div style="width: 45%;"> ___ The description of the employee's job duties at the time of injury (for injuries after 1/1/94) ___ The employee objects to the attached Notice of Intent to Withhold Maintenance Allowance </div> </div> Non-Expedited Issues: (Check the issue(s) that apply) ___ The employee objects to a Notice of Termination ___ The employee's medical eligibility for vocational rehabilitation services. Medical report relied upon by requester: _____ ___ The employer has failed to provide vocational rehabilitation services and benefits. My QRR preference is: (if any) _____ On what date should the employer have provided vocational rehabilitation services? ____ / ____ / ____ (Attach explanation) Date last worked ____ / ____ / ____ Date of last temporary disability ____ / ____ / ____ ___ The employee requested reinstatement and the employer failed to respond. On what date was request made to claims administrator? ____ / ____ / ____ How does the employee substantiate this request? [Attach supporting document(s)] ___ This is in response to a previously submitted RU-103 dated ____ / ____ / ____ ___ Other disputed issues (please describe the nature): _____					
Summary of Parties' Informal Efforts to Resolve this Dispute An informal conference was held on _____. A summary of the conference, including a list of attendees, issues addressed, agreements reached and other unresolved issues is attached. If an informal conference was not held, attach explanation.			Copies of this request with copies of medical and vocational reports have been served on:		
Name of Requester		Date		Signature	

**Rehabilitation Unit
California Division of Workers' Compensation**

Form RU-103

REQUEST FOR DISPUTE RESOLUTION

Purpose:

To request the Rehabilitation Unit to resolve a disputed rehabilitation issue.

Submitted by:

Any party of interest.

When submitted:

The form should only be submitted after all informal methods to resolve the rehabilitation dispute have been exhausted or in response to a RU-103 filed by the other party, or in response to a RU-105 Notice with which the employee disagrees.

Where submitted:

With the applicable Rehabilitation Unit district office. The Rehabilitation Unit's venue is the same as the WCAB's. If no WCAB case exists, file with a Rehabilitation Unit within the county where the injured employee resides.

Form completion:

This form will be returned or the request denied if:

- ♦ Liability for injury is in dispute.
- ♦ The form is incomplete.
- ♦ The requester has not attempted to resolve the dispute or such attempts have not been thoroughly documented on the form.
- ♦ Copies of all medical and vocational reports not previously filed are not attached.

Accompanying document:

Attach all medical and vocational reports not previously filed.

Response to RU-103:

The other parties shall have fifteen (15) days to respond by forwarding their position via a RU-103, with supporting information, to the correct Rehabilitation Unit District office with copies to all parties.

Rehabilitation Unit action:

The Rehabilitation Unit shall either issue a determination based on the record, request additional information, or set the matter for formal conference.

Copy:

All parties.

Please note: An expedited dispute resolution conference is to resolve a single issue as identified on the RU-103. If other issues are raised, a subsequent conference will be scheduled or a determination will be issued on the record.